Patti C. Huang, M.D., PA

Child Patient Information

Main Reason for today's visit: _____

Today's Date: / /		Primary Care Physician:		Referred to us by:
Patient's Name:			Parent's Email:	
Birth Date: / /		Sex:	Who does this child live with (mother, father, Grandpa, etc.)?	
Street Address:	City:	State:	Zip Code:	
Parent's Employer: Occupation:	Parent's Work#:	Parent's Home#:	Parent's Cell#:	
Emergency Contact:	Relationship to Patient:		Phone#	
Name of Primary Insurance	Policy Holder : Birth Date: / / SS#: -- --		Relationship to Patient Self/Spouse/Child	
Name Secondary Insurance	Policy Holder : Birth Date: / / SS#: -- --		Relationship to Patient Self/Spouse/Child	
Does your child attend daycare/preschool? Yes No And is so, where?				
Pharmacy Name & Location (Please name the cross streets and city of your most frequented pharmacy)				
Personal Heath History				
Please list any medical diagnoses received from other healthcare providers:				
Drug Allergies & Nature of Allergic Reaction:				
Medications (Rx and Non-Rx):		Surgeries/Hospital Admissions & Dates:		
Notes for Rx filled in by Dr. Huang: _____ _____				

Patti C. Huang, M.D., PA

Child Patient Information

Health Habits	
Exercise	○ Sedentary (no exercise) ○ Mild Exercise (i.e. climb stairs, walk 3 blocks, golf ○ Occasional vigorous exercise (i.e. less than 4x/week for 30 min) ○ Regular vigorous exercise (i.e. 4x/week for 30 min)
Caffeine	Does the child consume and caffeinated beverages? If so, what kind? To what extent? i.e. 1xdaily, 2xweekly
Tobacco	Is the child exposed to second-hand smoke? Is so, to what extent? i.e. 1xdaily, 2xweekly, etc.

Family Medical History

(Please specify where illness has occurred in your family)

Allergies	Mother	Father	Both	Neither	Other:
Anesthesia Complications	Mother	Father	Both	Neither	Other:
Asthma	Mother	Father	Both	Neither	Other:
Arthritis	Mother	Father	Both	Neither	Other:
Cancer	Mother	Father	Both	Neither	Other:
Cardiovascular Issues: Hypertension and/or Stroke	Mother	Father	Both	Neither	Other:
Diabetes	Mother	Father	Both	Neither	Other:
Hearing Loss	Mother	Father	Both	Neither	Other:
Mental Illness	Mother	Father	Both	Neither	Other:
Obesity	Mother	Father	Both	Neither	Other:
Osteoporosis	Mother	Father	Both	Neither	Other:

Current Symptoms

(Please circle any current symptoms your child is having and mark through those he/she are not experiencing)

Allergy	Runny Nose	Scratchy Throat	Ear fullness	Stuffy Nose
	Sinus Congestion	Itchy Eyes		
Cardiology	Chest Pain	Heart Murmur	Shortness of Breath	Elevated Blood Pressure
Ears	Ear drainage	Ringing	Balance Problems	Hearing Problems
Eyes	Blurry Vision	Double Vision	Spotted Vision	
Gastrointestinal	Vomiting	Nausea	Constipation	Blood in Stool
	Diarrhea	Heartburn		
Musculoskeletal	Joint Pain	Stiffness	Chronic soreness	
Neurologic	Headache	Tingling/Numbness	Seizures	Migraine
Nose	Excessive Sneezing	Nasal itching	Watery eyes	Nasal Obstruction
	Loss of smell	Snoring		
Psychiatric	Depression	Anxiety	Panic Attacks	
Respiratory	Wheezing	Coughing	Chest congestion	Recent Bronchitis
Throat	Difficult or painful swallowing	Sore throat	Hoarseness	

Frisco Family ENT

Phone: 214-374-8264 Fax: 214-297-0073

We ask for your insurance information when we schedule your first appointment, and we make every effort to verify your coverage and benefits. While we do our best to verify that our doctors are contracted and in-network with your insurance plan, it is ultimately your responsibility to ensure that this is the case. We call your insurance company and ask for specific benefits for procedures that are common in our ENT practice. Based upon information provided to us by your insurance company, we will expect payment according to the benefits quoted. Upon check-in, we will expect payment of the full amount of your co-payment. After you see one of our providers, we will expect payment of any deductible and co-insurance amounts based on the services rendered. We will then file your insurance claim with your insurance company for that visit. When they process your claim, they will mail both you and our office an Explanation of Benefits (EOB). When we receive the EOB, we will adjust any contracted discounts off of your account for that visit. We will post any payments received for the insurance company to your account for that visit. All outstanding balances are due in full upon receipt of statement.

Many insurance plans have a requirement that patients must provide additional information to them **before** they will pay your claim. When this is the case, your insurance company will inform us that they have "pended" your claim for additional information. If that happens, the **full balance** due on your visit becomes your responsibility to pay. Once an insurance company "pends" a claim, there is **nothing** that our office can do to get the claim paid; it is completely up to the patient to contact their insurance company, provide the needed information, and ensure that the insurance company pays the claim within thirty days. Additionally, if your insurance plan, group number or policy number changes, you must notify us at the time of service. Failure to provide us with current valid insurance information will result in the entire balance becoming your responsibility. This is because health care providers only have a certain amount of time in which to file your insurance claim; this timely-filing deadline varies with each insurance company. Also, visits that have been filed in a timely fashion and go unpaid by you insurance company for 60 days will be transferred to your financial responsibility. **Please remember that our office files on your insurance as a courtesy to you and is not legally required to do so.** It is important to remember that your insurance policy is a contract **between you and the insurance company.** We will do everything possible to assist you in getting your claim paid, however all charges incurred for your medical care are your sole financial responsibility.

Medically Necessary Services-

Insurance regulations require that in order to collect payment for services rendered, your doctor informs you in advance when a service may not be deemed "medically necessary" by Medicare guidelines, even though the doctor believes these services are required in order to provide you with the best quality of care you are owed. Based on past occurrences, the following service might not be paid by your insurance:

Hearing Examinations	***Pathologic Examinations***	***Fiberoptic Laryngoscopy***	***Nasal Endoscopy***	***Cerumen Removal***	***Surgical Procedures***

By signing this statement, you are agreeing to pay for these services yourself even if they are determined by your insurance to not be "medically necessary."

Non-Covered Services-

A non-covered service is any service that is denied by your insurance carrier due to benefit descriptions or limitations, policy exclusions, or pre-existing waiting periods. Non-covered services will be the responsibility of the patient and payment is due at the time of service. Please contact your insurance carrier and inquire about any service that may be non-covered. If you receive a service that is considered non-covered by your insurance plan, you will be expected to make payment in full.

Referrals/Authorizations-

Should your insurance company require a referral or authorization, it is your responsibility to obtain or request one prior to your appointment**.**

Returned Payment-

Payment is accepted in the form of cash, check (except for new patients and surgery), credit card (expect American Express), and debit. Should a payment be returned for any reason, including but not limited to, insufficient funds, stop payment, or closed account, the patient will be liable for the original amount plus any associated NSF fees. Our current NSF fee is $25.00.

Medical Records-

1) I understand the Texas State Board of Medical Examiners allows 2 weeks for the processing of my records.
2) I understand that if I request medical records, there is a fee which must be paid prior to the records being copied. According to the Texas State Board of Medical Examiners, the allowable fee is $25.00 for the first twenty pages and $.50 for each additional page.
3) I understand that there will be a $ 35 fee for any FMLA Paperwork completed (Surgery patients)

Frisco Family ENT

Phone: 214-374-8264 Fax: 214-297-0073

Your co-Payment is due at check-in, prior to seeing the doctor. Any deductibles and co-insurance portions must be paid at check-out for services rendered at that visit. If you are unable to pay your portions at the time of service, we ask that you reschedule your appointment or make prior financial arrangements with our billing department.

I, _____ , do hereby affirm that I have read and understand the above financial policies. I understand that I am financially responsible for all medical fees incurred during my treatment regardless of insurance coverage of benefits.

(Print Name) (Signature of Patient/Guardian) (Date)

Consent for Treatment, Missed Follow –Up Appointments, and Returned Check Policies

I hereby give authorization to the physician and medical staff of Dr. Patti C. Huang M.D., PA to provide medical treatment and care. I understand that no guarantees have been made with regards to treatment successes and that there may be complications associated with either my condition or with its proposed treatment.

I understand that failure to appear at a scheduled follow-up appointment may result in a delay in the diagnosis or treatment of a potentially serious condition. This office will call in advance to remind the patients of their upcoming appointments and will try to reschedule if the appointment cannot be kept. However, this office will not be held responsible for complications arising from missed appointments due the patient's non-compliance. **We reserve the right to charge $25 for missed appointments. There will be a $50 cancellation fee for cancellation of surgery due to non-medical reasons**. **A $25 fee will also be assessed for all checks returned unpaid. Payment is expected at the time of service upon check-in unless prior arrangements have been made.**

Signature of PATIENT/Patient's Parent or Guardian _____

PATIENT'S Name Printed _____

Date _____

Frisco Family ENT

Phone: 214-374-8264 Fax: 214-297-0073

Consent to Release Protected Health Information (PHI)

I understand that in order to disclose my PHI, Frisco Family ENT, must have my consent. Therefore, I authorize Frisco Family ENT to disclose my PHI as described in the HIPAA Notice of Privacy Practices, to the recipients listed below: Description of the information to be disclosed **(CHECK ALL THAT APPLY):**

☐ All Information ☐ Test Results ☐ Appointments ☐ Surgeries ☐ Billing/Account Information ☐ Other

I specifically authorize Frisco Family ENT to use and disclose verbally, or fax the following types of ***super-confidential information*** as stated in the NOPP **(CHECK ALL THAT APPLY)**

☐ HIV records (Including HIV test results) and sexually transmissible diseases

☐ Alcohol and substance abuse diagnosis and treatment records

☐ Psychotherapy records

☐ Not Applicable

May we discuss the above information with your Primary Care Physician ☐ Yes ☐ No

If so, please list the name of your Primary Care Physician: _____

Name(s) of other people authorized to obtain the above-mentioned information.
(E.g. family members, and other specified person/persons, Physician (other than your primary care physician))

Name: _____ Relationship: _____ Tel: _____
Name: _____ Relationship: _____ Tel: _____
Name: _____ Relationship: _____ Tel: _____
Name: _____ Relationship: _____ Tel: _____

Contact Information:

***Please list the **BEST** phone number that our office may contact you regarding appointment reminders and all other medical correspondence: _____

May we leave a detailed message on your answering machine or voicemail? ☐ Yes ☐ No

I approve being contacted about **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of Frisco Family ENT
☐ Yes ☐ No

In signing this HIPAA Patient Acknowledgement form, you acknowledge and authorize, that you hold harmless the Healthcare Facility, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring from this authorization. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until this federal and state law has expired and the records have been destroyed; that I have the right to revoke this authorization at any time, provided I do so in writing; that I have been given the opportunity to ask question; that I have received a copy of the signed authorization; that I may inspect a copy of my PHI to be used or treatment of me upon receipt of this signed authorization; and that I may refuse to sign this authorization. A copy of this signed, dated Authorization shall be as effective as the original.

Patient or Representative: _____ **Relationship:** _____

Office Witness: _____ **Date:** _____